IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 22, 2002

Re: IRO Case # M2-02-1038

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

> History
> The patient is a now 35-year-old male who was in a motor vehicle accident in ___ and developed low back and thoracic region pain. His discomfort continued despite physical therapy, chiropractic treatment, TENS unit, and considerable medication. The patient has not had significant lower extremity discomfort. His pain is primarily in the lumbar spine, but he also has pain elsewhere in the spine. Imaging reports were not provided for this review, but reports of physicians who referred to those reports were provided. A lumbar CT with contrast was reported to show an annular tear with a central disk herniation at L5-S1. An MRI 9/11/00 reportedly had similar findings.

Requested Service
Selective endoscopic discectomy at L4-5, L5-S1

Decision
I agree with the carrier's decision to deny the requested surgery.

Rationale
The MRI and CT scans reportedly only slightly suggest difficulties that would be correctable by the proposed procedure. In addition, the discogram, which while positive, does not show in any report provided for this review, any production of concordant pain. A note recorded on 1/7/02 states that the patient has "intractable mid thoracic pain," and it is doubtful that the proposed procedure would be of any benefit in relieving that problem. I agree that there is insufficient evidence to warrant authorization for the proposed procedure.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to:
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 24th day of October 2002.